Senate Budget and Fiscal Review—Denise Moreno Ducheny, Chair

SUBCOMMITTEE NO. 4 Agenda

Senator Mark DeSaulnier, Chair
Senator Tom Harman
Senator Gloria Negrete McLeod

Thursday, March 18, 2010
9:30 a.m. (or upon adjournment of session)
Room 112

Consultant: Brian Brown

Item Number and Title **Page**

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California Prison Health Care Services (Receiver)

Background – History of the *Plata* Case, Current Plan, and Progress

Origination of the *Plata* Case and Consent Decree. In 2001, inmates filed a class action suit alleging that the California Department of Corrections (now the California Department of Corrections and Rehabilitation) was providing constitutionally inadequate medical care at all state prisons. The court has found that on average an inmate died needlessly every six to seven days due to inadequate medical treatment. The court cited the rapid growth of the prison system and a lack of organizational restructuring to accommodate this growth, as well as a lack of accountability, as principal drivers of the inadequate medical care provided.

In 2002, the state and plaintiffs entered into a consent decree which provided the federal court the power to enforce the agreement. The state was ordered to implement new policies and procedures on a staggered basis, with seven prisons required to complete implementation in 2003, and five additional prisons for each succeeding year until state-wide compliance was achieved. In 2004, court experts reported emerging patterns of inadequate compliance, including deficient physician quality. The state agreed to evaluate its physicians, provide additional training, undertake new measures regarding high-risk patients, develop proposals regarding physician and nursing classifications and supervision, and staff Quality Management Assistance Teams.

Establishment and Mission of the Federal Receiver. In 2005, the court found that the state continued to suffer from "entrenched paralysis and dysfunction" and issued its ruling that it would appoint a receiver to run the state's prison medical care system. In its ruling the court cited major ongoing deficiencies including incompetent physicians and nurses, the poor quality of health care supervisors and management, a lack of meaningful peer review, inadequate intake screening and treatment, limited access to care, inadequate medical records systems, medical facilities in poor physical condition, interference by custodial staff, and failure to perform adequate investigations of medical staff.

In February 2006, the court appointed Robert Sillen as the receiver and outlined the duties of the Receiver, including providing day-to-day management of the prison medical care delivery system with the goal of "developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all class members as soon as practicable." In January 2008, the court appointed J. Clark Kelso as the new receiver.

Turnaround Plan of Action. The February 14, 2006 Order Appointing Receiver requires the Receiver to "develop a detailed Plan of Action designed to effectuate the restructuring and development of a constitutionally adequate medical health care delivery system." The Receiver's "Turnaround Plan of Action" was submitted to the Court on June 6, 2008. On June 16, 2008, the Court approved the plan "as a reasonable and necessary strategy to address the constitutional deficiencies in California's prison health care system", also finding "the plan's six strategic goals to be necessary to bring California's medical health care system up to constitutional standards." The objectives of the Turnaround Plan of Action are identified in the following table.

Receiver's Turnaround Plan of Action

Goal 1. Ensure Timely Access to Health Care Services	
Objective 1.1	Redesign and Standardize Screening and Assessment Processes at Reception/Receiving and Release
Objective 1.2	Establish Staffing and Processes for Ensuring Health Care Access at Each Institution
Objective 1.3	Establish Health Care Scheduling and Patient-Inmate Tracking System
Objective 1.4	Establish A Standardized Utilization Management System
Goal 2. Establish Medical Program Addressing the Full Continuum of Health Care Services	
Objective 2.1	Redesign and Standardize Access and Medical Processes for Primary Care
Objective 2.2	Improve Chronic Care System to Support Proactive, Planned Care
Objective 2.3	Improve Emergency Response to Reduce Avoidable Morbidity and Mortality
Objective 2.4	Improve the Provision of Specialty Care and Hospitalization to Reduce Avoidable Morbidity and Mortality
Goal 3. Recruit, Train and Retain a Professional Quality Medical Care Workforce	
Objective 3.1	Recruit Physicians and Nurses to Fill Ninety Percent of Established Positions
Objective 3.2	Establish Clinical Leadership and Management Structure
Objective 3.3	Establish Professional Training Programs for Clinicians
Goal 4. Implement Quality Improvement Programs	
Objective 4.1	Establish Clinical Quality Measurement and Evaluation Program
Objective 4.2	Establish a Quality Improvement Program
Objective 4.3	Establish Medical Peer Review and Discipline Process to Ensure Quality of Care
Objective 4.4	Establish Medical Oversight Unit to Control and Monitor Medical Employee Investigations
Objective 4.5	Establish a Health Care Appeals Process, Correspondence Control and Habeas Corpus Petitions Initiative
Objective 4.6	Establish Out-of-State, Community Correctional Facilities and Re-entry Facility Oversight Program
Goal 5. Establish Medical Support Infrastructure	
Objective 5.1	Establish a Comprehensive, Safe and Efficient Pharmacy Program
Objective 5.2	Establish Standardized Health Records Practice
Objective 5.3	Establish Effective Radiology and Laboratory Services
Objective 5.4	Establish Clinical Information Systems
Objective 5.5	Expand and Improve Telemedicine Capabilities

Goal 6. Provide for Necessary Clinical, Administrative and Housing Facilities	
Objective 6.1	Upgrade administrative and clinical facilities at each of CDCR's 33 prison locations to provide patient-inmates with appropriate access to care
Objective 6.2	Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs
Objective 6.3	Complete Construction at San Quentin State Prison

Implementation Progress. The receiver is required to provide reports to the court three times annually regarding progress implementing the Turnaround Plan of Action. The most recent report was issued in January 2010 and is available on the California Prison Health Care Services (CPHCS) website. The report identifies the status of each objective at each state prison as well as provides a target completion date for the statewide completion of each objective.

In addition, the CPHCS has entered into an agreement with the Office of the Inspector General (OIG) to evaluate and monitor the progress of medical care delivery to inmates by establishing an objective, clinically appropriate, and metric-oriented medical program to annually inspect the delivery of medical care at each state prison. The first inspection report – for the California State Prison, Sacramento – was issued in November 2008. In total, 19 inspection reports have been completed through March 2010. The OIG reports that it intends to complete an inspection of each prison annually. The table below summarizes the compliance rate found for each category assessed during the first 19 inspections.

Summary of Office of Inspector General Medical Inspection Findings

Category	Average Score	Median Score
Chronic Care	62.7%	62.7%
Clinical Services	65.5%	65.9%
Health Screening	74.6%	74.3%
Specialty Services	60.2%	60.6%
Urgent Services	78.1%	80.2%
Emergency Services	77.2%	78.1%
Prenatal Care/Childbirth/ Post-Delivery	61.3%	61.3%
Diagnostic Services	69.6%	70.0%
Access to Healthcare Information	60.0%	58.8%

Outpatient Housing Unit	76.7%	75.4%
Internal Reviews	76.2%	70.4%
Inmate Transfers	87.9%	95.3%
Clinic Operations	90.7%	90.6%
Preventive Services	36.9%	32.1%
Pharmacy Services	85.1%	90.8%
Other Services	81.4%	85.0%
Inmate Hunger Strikes	43.4%	44.2%
Chemical Agent Contraindications	89.3%	94.1%
Staffing Levels and Training	93.9%	95.0%
Nursing Policy	72.6%	71.4%
Overall Score	**70.2%**	**71.3%**

Three-Judge Panel and Population Cap. In August 2009, a panel of three judges overseeing the *Plata* case as well as cases involving inmate mental health care and disability issues ordered the state to reduce overcrowding in the existing 33 state prisons. It made this order based on finding that overcrowding was a primary cause of unconstitutional care and that no other relief is capable of remedying deficiencies. The court ordered that overcrowding be reduced to 137.5 percent of "design capacity" within two years which would result in prison population reductions of approximately 40,000 inmates. The court reaffirmed its decision and ordered the implementation of the state's plan in a January 2010 order. The decision is currently being appealed.

Staff Comments on the History of the *Plata* Case, Current Plan, and Progress. The committee may wish to direct the following questions to the Receiver's Office.

- What does the Receiver view as the most important strides made to date towards implementing the objectives of the Turnaround Plan of Action? What does the Receiver view as the most critical next steps towards successful implementation?

- How will the Receiver and the court determine when it is appropriate to return control over the prison health care system to the state? To what extent will that decision be guided by the empirical findings of the OIG inspections versus other criteria?

- What is the projected timeframe for the successful end of the receivership?

- How is the Receiver's Office using the information provided by the OIG's medical inspections to improve the provision of inmate medical care on a day-to-day basis?

Fiscal Overview

Growth in Prison Health Care Costs. Prison health care costs have grown substantially since the beginning of the *Plata* case. The state spent about $800 million on inmate health care (including medical, mental, and dental health) in 2001, the year that the case was filed. The administration estimates that the state will spend $2.2 billion on inmate health care this year.

Interestingly, this nearly three-fold increase in expenditures occurred during a period in which the inmate population grew by less than five percent. Consequently, the average per inmate cost of inmate health care grew from about $4,900 in 2001-02 to about $13,500 in 2009-10.

According to a January 2009 report from CDCR, state expenditures for inmate health care have increased by $1.2 billion as a result of implementing the provisions of the three major class action suits in this area. The *Plata* case has resulted in increased costs of about $810 million, while the *Coleman* (mental health) and *Perez* (dental health) cases have resulted in an additional $423 million in costs annually. In the *Plata* case, the most significant budget increases have been associated with increased medical staffing levels, salary increases, pharmaceutical and medical supplies, and increased custody staff for medical guarding, access, and transportation.

Medical Staffing Levels. The Receiver's tri-annual reports to the federal court provides an update of staffing levels for medical positions in the department. The following table summarizes the staffing levels for specified positions as of November 2009.

Classification	Positions Authorized	Percent Filled
Physicians and surgeons	317.9	87%
Supervising Registered Nurse (II and III)	443.7	81%
Registered Nurse	1,718.1	89%
Licensed Vocational Nurse	1,135.5	86%
Psychiatric Technician	558.6	89%
Pharmacist (I and II)	138.7	75%
Pharmacist Tech	140.0	95%
Total, all positions	*4,651.0*	*87%*

Summary of Budget Proposals. The Governor's budget includes proposals resulting in a net *reduction* of $279 million in the prison health care budget in 2010-11 compared to the current year authorized spending level. This includes an increase of $532 million associated with various budget proposals and projects designed to implement the receiver's turnaround plan. Most of these increases are associated with (1) a request for $209 million to bring the budget for contracted and registry services up to the projected expenditure level, and (2) $235 million related to 19 different IT projects and management efforts designed to implement the turnaround plan.

In addition, the Department of Finance notified the Legislature in February that it will seek a Supplemental Appropriations Bill for $517.5 million in additional current-year funding authority for the CPHCS. About $515 million of that amount is associated with (1) contracted and registry services ($404 million), and (2) the 19 projects ($111 million). The remaining $2.6 million is associated with contracted medical costs associated with the August 2009 riot at the California Institution for Men.

The following table summarizes the annual costs associated with each of the budget proposals included in the Governor's budget.

Summary of Receiver Proposals
(In Millions)

Proposal	2009-10	2010-11	2011-12	2012-13	2013-14
Expenditures					
Medical services contracts	$404	$209	$209	$209	$209
Pharmaceuticals and med. supplies	$0	$46	$0	$0	$0
Nursing relief	$0	$24	$24	$24	$24
Medication management	$0	$10	$10	$10	$10
Health information management	$0	$8	$9	$9	$2
Section letter: position redirection	$0	$0	$0	$0	$0
PMO: 19 Projects	$111	$235	$210	$155	$109
Subtotals	*$515*	*$532*	*$462*	*$407*	*$354*
Savings					
Unallocated reduction	$0	-$811	-$811	-$811	-$811
Net Cost/Savings	**$515**	**-$279**	**-$349**	**-$404**	**-$457**

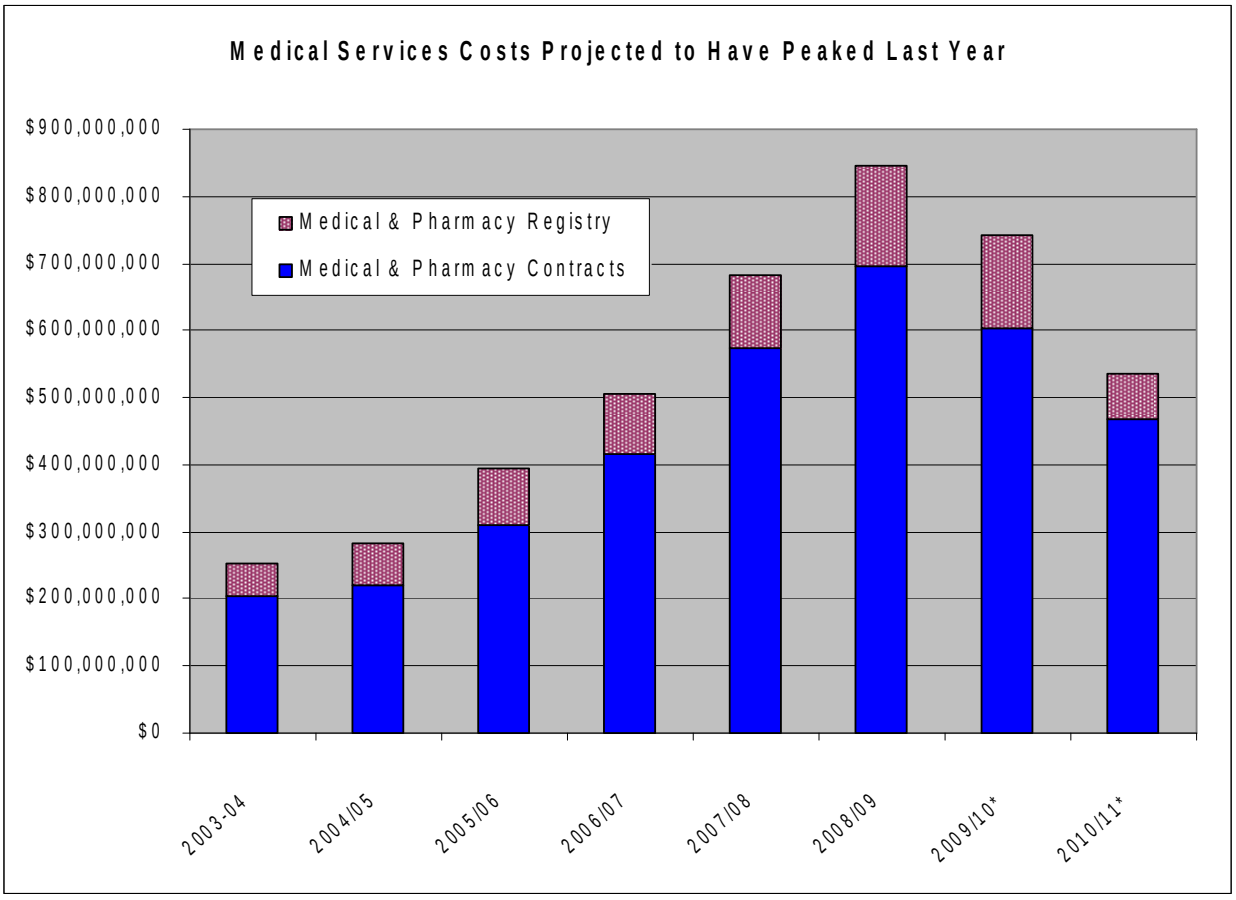
Staff Comments on Fiscal Overview. The committee may wish to consider the following questions.

- Is the Legislature confident that the requested resources are necessary to bring the prison health care system to a constitutional level of care?

- Is the request by the Receiver's Office for $517.5 million in additional current year authority – to be achieved through a supplemental appropriations bill – warranted? How much has the CPHCS spent to date for these purposes?

Issue 1 – Medical Services Contracts

Background. The prison health care system incurs significant contract-related costs. This includes costs for registry staff, especially for nurses, as well as other contract costs, particularly related to providing inmates with referrals to outside health care providers. The figure below shows that these costs have increased from about $252 million in 2003-04 to $845 million last year. The Receiver's Office projects these costs to decrease to $741 million this year and to $537 million in 2010-11 due to various efforts to curtail these costs. Some of these efforts are described in more detail below.



***** *Projected.*

The base budget for medical services contracts, including registry, totals about $308 million. Adding to that estimated salary savings from vacant prison health care positions, the Receiver's Office estimates a total shortfall of $403.6 million in the current year and $208.9 million in the budget year.

Governor's Budget Request. The Receiver's Office requests $208.9 million in the budget year and ongoing to address the base funding shortfall for medical services contracts. In addition, the Receiver's Office has submitted notification to the Legislature that it will seek $403.6 million in additional current year funds in a supplemental appropriations bill for the same purpose.

	2009-10	2010-11	2011-12
General Fund	$403,575,000	$208,892,000	$208,892,000
PY's	0.0	0.0	0.0

Staff Comments. As described above, the Receiver's Office estimates that it can reduce its medical contracts and registry costs by 12 percent in the current year (which it is on pace to do through the first six months of 2009-10) and an additional 28 percent in the budget year. The Receiver's proposals to increase the nursing relief factor and adding nursing staff for medication distribution (described in more detail in Issues 3 and 4 of this agenda) are among the factors the CPHCS cites for how it will achieve these spending reductions. Efforts to reduce these costs should be supported. However, it is notable that even with these projected reductions, spending in this area will exceed the expenditure levels of 2005-06 – the year the position of the Receiver was established – by $143 million.

The Receiver's budget request identifies increased access to care under the Receivership as the primary reason for increased costs in this area, particularly because better access to care has resulted in increased referrals to specialty services that otherwise would not have been provided. Typical contracted services include acute outpatient care at a hospital, including infirmary care and observation room services, acute inpatient care, emergency room care, and outpatient specialty care.

The CPHCS reports that it is implementing several cost containment measures in an attempt to reduce or stabilize cost in this area. These measures include implementation of utilization management, which is designed to utilize a criteria-based decision-making process to determine the most appropriate treatment, including whether referral to outpatient specialty services is warranted. Another cost containment effort noted by the Receiver's Office is utilization of a third party administrator to pay medical invoices and reduce errors and duplicative payments.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- How much of the historical increases in medical contracts and registry costs are attributable to specific factors, such as specific diagnoses, increased referrals, and increased costs per referral?

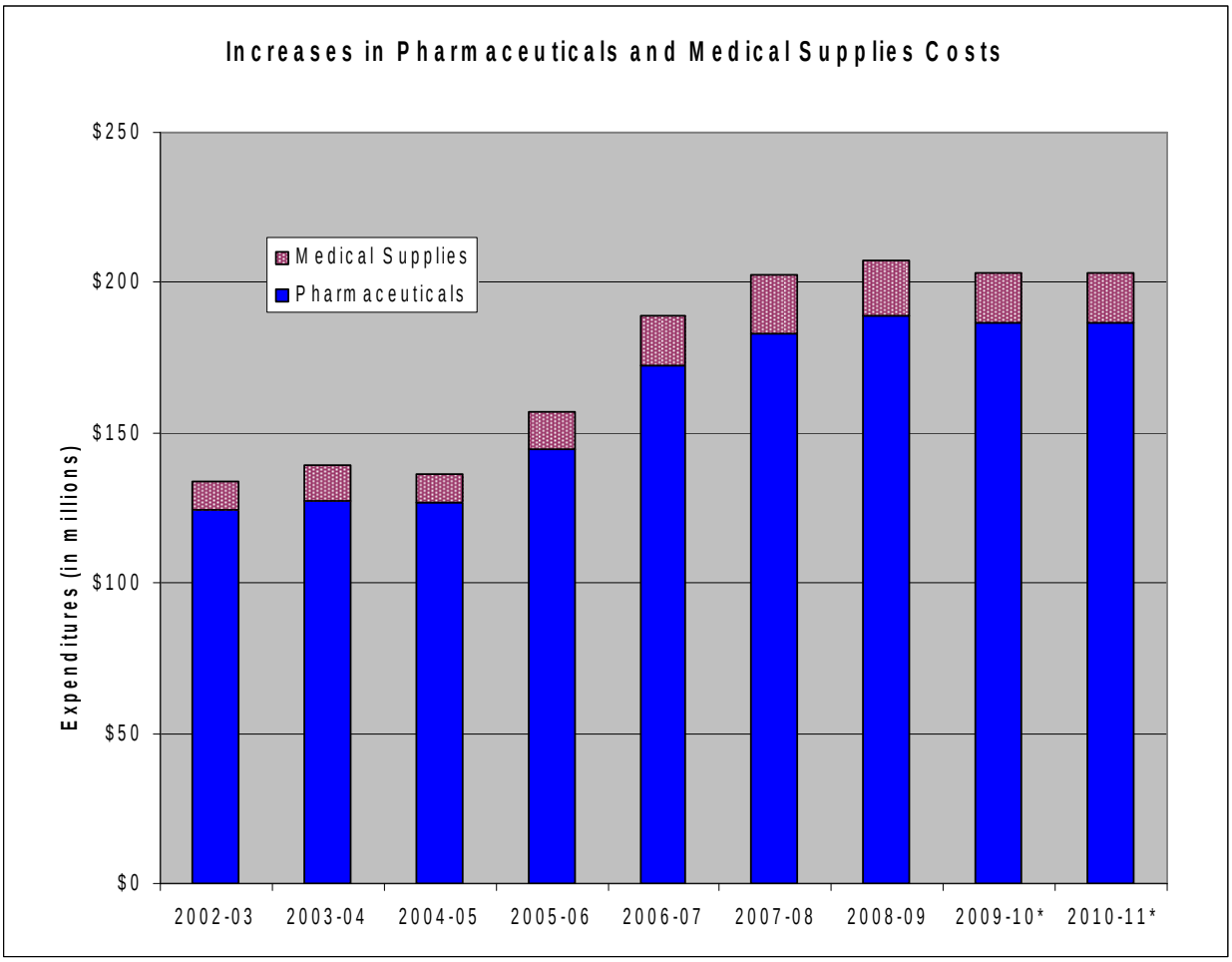
- What efforts is the Receiver's Office taking to reduce medical contract and registry costs?

- Is the Receiver's Office on track to meet its goal of reducing these costs from $845 million to $741 million this year? If so, to what would the Receiver attribute these reductions? If not, what has hampered his ability to make these reductions?

- In addition to overall expenditures in this area, what are the key performance outcomes the Receiver's Office is tracking to monitor progress in its efforts to manage these programs?

Issue 2 – Pharmaceuticals and Medical Supplies

Background. The CPHCS has a base budget for pharmaceuticals and medical supplies of $139.6 million in 2010-11. As the figure below illustrates, total expenditures in this area have increased in recent years before leveling off at about $200 million. Over 90 percent of these costs are for pharmaceuticals.



** Projected.*

From 2007-08 through 2008-09, the Legislature provided an additional $45.8 million to the Receiver's base budget to help cover the shortfall in these areas. This augmentation was provided on a limited-term basis, after which a new assessment of need would be conducted to determine the permanent funding amount necessary to cover these expenditures.

Governor's Budget Request. The CPHCS requests $45.8 million in 2010-11 (one-time) to augment its pharmaceuticals and medical supplies budget. The Receiver's Office cites a delay in the implementation of the Central Fill Pharmacy as the reason for the need to extend the limited-term funding for an additional year.

	2009-10	2010-11	2011-12
General Fund	$0	$45,800,000	$0
PY's	0.0	0.0	0.0

Staff Comments. The CPHCS cites three primary reasons for this augmentation. These factors are (1) poor health among the inmate population, particularly given the aging of the inmate population, (2) increased drug costs of more than 5 percent annually, and (3) a 14 percent increase in the number of prescriptions written between 2006 and 2009, primarily due to increased access to care under the *Coleman* and *Plata* cases.

The Receiver's Office notes several steps it has taken to manage costs in this area, including implementation of a formulary, implementation of a pharmacy software system, and development of plans to institute a centralized pharmacy facility for the consolidation and distribution of drugs. The CPHCS reports that these changes will allow for increased inventory control, more effective purchasing oversight, enhanced patient safety, and lower overall pharmacy operating costs. It further reports that the Central Fill Pharmacy is scheduled to open in the summer of 2010 and will result in savings of at least $5 million annually from pharmaceutical waste alone.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- Why have the efforts so far implemented, particularly the implementation of the formulary and use of generic drugs not resulted in any reduction in pharmacy costs? Can the CPHCS provide data on the extent to which the formulary and generic drugs are utilized?

- Does the Receiver believe that the efforts being undertaken can reduce pharmaceutical costs, or is it more likely that these efforts will simply slow the rate at which these costs grow in the future? In other words, how likely is it that this $45.8 million request will be an ongoing budgetary need?

- Has the Receiver's Office evaluated the rate at which inmates receive prescriptions in California prisons as compared to other prisons or jails? If so, what were the findings and implications? If not, would that be a worthy evaluation to conduct?

Issue 3 – Nursing Relief

Background. The department is currently authorized for 1,641 Registered Nurse (RN) and 1,117 Licensed Vocational Nurse (LVN) PY's. Because these positions typically need to be backfilled when vacant, the state budgets a relief factor for these positions. The relief factor is an estimate of the total PY's needed to fill a position including when it is vacant due to reasons such as vacation, illness, regular days off, and training. The current relief factor for RN's is 1.66 and for LVN's is 1.71.

This means, for example, that for each RN post that must be filled seven days per week, 1.66 PY's need to be authorized and funded to ensure that the post will be filled throughout the year. (It should be noted that a lower relief factor is used for positions that only need to be filled five days per week.)

By comparison, the relief factor for correctional officers is 1.76.

Governor's Budget Request. The Receiver's Office requests $23.5 million and 201.7 PYs ongoing to increase the relief factor for RN's to 1.77 and LVN's to 1.75.

	2009-10	2010-11	2011-12
General Fund	$0	$23,516,000	$23,516,000
PY's	0.0	201.7	201.7

The following tables compare the current relief factors for RN's and LVN's to what is being proposed by the Receiver's Office. An additional 13 days of relief are being requested for RN's, and 4.7 more days of relief are being requested for LVN's. Most of this change is attributable to additional training days for these positions, as well as the addition of a relief calculation for bereavement, military, and FMLA leaves. In addition, sick leave relief for RN's is proposed to be increased.

Comparison of Current and Proposed Relief Factors for RN's and LVN's

Registered Nurse

	Current		Proposed	
	Days	Relief Factor	Days	Relief Factor
Base position	219.5	1.00	206.5	1.00
Regular days off	104.0	0.47	104.0	0.51
Vacation	13.5	0.06	12.7	0.06
Holiday	14.0	0.06	14.0	0.07
Sick leave	9.0	0.04	12.0	0.06
Training	5.0	0.02	12.9	0.06
Bereavement	0.0	0.00	0.4	0.00
Military	0.0	0.00	0.1	0.00
FMLA	0.0	0.00	2.5	0.01
Totals	***365.0***	***1.66***	***365.0***	***1.77***

Licensed Vocational Nurse

	Current		Proposed	
	Days	**Relief Factor**	**Days**	**Relief Factor**
Base position	214.1	1.00	209.4	1.00
Regular days off	104.0	0.49	104.0	0.50
Vacation	15.9	0.07	13.5	0.06
Holiday	14.0	0.07	14.0	0.07
Sick leave	12.0	0.06	12.0	0.06
Training	5.0	0.02	10.9	0.05
Bereavement	0.0	0.00	0.4	0.00
Military	0.0	0.00	0.2	0.00
FMLA	0.0	0.00	0.7	0.00
Totals	***365.0***	***1.70***	***365.0***	***1.75***

Staff Comments. The Receiver's Office estimates that it spent about $27 million 2008-09 in registry and overtime costs related to backfilling unfunded relief. The Receiver's Office further notes that overtime and registry is significantly more expensive than hiring new employees. Specifically, the CPHCS provided estimates that show that over the course of a year, using overtime for an RN or LVN is about 14 to 15 percent more expensive than using a civil service employee, including the cost of benefits, and using registry is 22 percent more expensive for RN's and 47 percent more expensive for LVN's than using a civil service employee.

The Receiver estimates that this proposal will provide offsetting savings of $26 million in reduced overtime and registry usage. These cost reductions are reflected in the reduced spending estimates in the Medical Services Contracts item (Issue 1 of this agenda) discussed above. Based on the Receiver's estimates of offsetting cost reductions, the net savings associated with this proposal are about $2.4 million.

For purposes of comparison, it is worth noting that the 2004-05 budget included $99.5 million to increase the relief factor for correctional officers from 1.67 to 1.76. One of the principal justifications for this proposal was that it would reduce the department's reliance on overtime and temporary help. At the time, the department reported running deficiencies for those purposes of $79 million. Despite the Legislature's approval of the request, the department overspent its budget for custody positions by roughly $350 million in 2007-08. This suggests that, despite the logic, providing additional relief positions does not necessarily result in reductions in overtime or temporary help (including registry) usage. Instead, it suggests that usage and spending on overtime and temporary help is at least partly dependant on other factors which probably include workload and the willingness and ability of administrators to track and manage the usage of overtime and temporary help by employees.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- If overtime and registry are significantly more expensive than using relief staff, shouldn't this proposal result in greater net cost reductions than $2.4 million which is about 10 percent of the augmentation request?

- What will the Receiver's Office do to ensure that prison administrators effectively track and manage overtime and registry usage to actually reduce these costs going forward?

Issue 4 – Medication Management

Background. Inmates in prison receive prescribed medications in "pill calls" four times per day. The Receiver's Office estimates that it makes about 85,000 medication distributions each day during these pill calls. According to the budget request, the department current has 549 LVN's budgeted.

The Receiver's Office estimates that it has an insufficient number of LVN's positions to distribute the number of medications required. It bases this conclusion on time motion studies that show that an LVN can distribute approximately 30 medications per hour. In addition, the Receiver's Office estimates that it spends about $39 million annually on overtime and registry in order to complete medication distribution each day.

Governor's Budget Request. The CPHCS requests $10.1 million in 2010-11 ($9.9 million ongoing) and 145 LVN's to improve distribution of medications to inmate-patients.

	2009-10	2010-11	2011-12
General Fund	$0	$10,085,000	$9,926,509
PY's	0.0	145.0	145.0

Staff Comments. The Receiver's budget proposals assume that this request will effectively eliminate the use of overtime and registry for purposes of medication management. This $39 million reduction in costs is reflected in the Medical Services Contracts item (Issue 1 of this agenda) discussed above. Based on the Receiver's estimates of offsetting cost reductions, the net savings associated with this proposal are about $29 million annually.

The budget request is based on assumptions that there are two two-hour pill calls during each of second and third watch (shifts). However, the budget request does not detail what the LVN's will be doing during the other four hours of each watch.

Staff notes that while the budget request identifies 549 LVN positions available for medication management, the most recent tri-annual report identifies 1,135.5 authorized LVN positions in total. Presumably, the other positions have other treatment and medical care responsibilities within the institution.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- Do LVN's have other job requirements in prisons, or are they primarily responsible for medication distribution?

- The calculations for this request are based on an assumption that there are two two-hour pill calls per shift. What will the LVN's be doing the other four hours each shift?

Issue 5 – Health Information Management (HIM)

Background. A number of audits and reports have found major deficiencies with how CDCR has managed inmate health care records. Deficiencies include a lack of a uniform and standardized health information system, insufficient training of health records staff, inappropriate staffing, various filing methods used at different institutions, multiple health records sites at some prisons, duplication of forms, loose records not being filed, and incorrectly packaged health records. Most of these problems appear to stem from the reliance on a paper-based rather than a centralized electronic medical records system, as well as a lack of centralized oversight and management.

Governor's Budget Request. The Receiver's Office is requesting $8.5 million and 14.1 PY's in 2010-11 to implement its Health Information Management (HIM) program. Much of this amount is proposed as a three-year limited term request, while $1.7 million and 2.9 PY's would be ongoing.

	2009-10	2010-11	2011-12	2012-13	2013-14
General Fund	$0	$8,492,000	$9,910,000	$9,910,000	$1,700,000
PY's	0.0	14.1	14.1	14.1	2.9

The Receiver's HIM program has three components:

- ***Remediate and Support Paper Record Management.*** The Receiver proposes to create two teams utilizing a total of 14 contract staff that will spend three months in each prison to assist health care staff establish uniform processes and workflows for managing health records. This will be followed by a two month follow-up period where four limited term staff will be responsible for providing ongoing oversight and support to ensure that the implemented changes have been maintained. In total, this effort is expected to take three years to complete in all prisons.

- ***Integrate Electronic Record (e-Record) Components.*** The Receiver proposes to create two teams utilizing an additional eight contract staff to manage the implementation of various electronic medical records initiatives statewide. This effort will happen in concert with the remediation efforts described above.

- ***Pilot Content Management.*** The Receiver's Office proposes three permanent positions that will be involved in the scanning of all health records documents at two prisons, the Central California Women's Facility and Valley State Prison for Women, both located in Chowchilla.

Staff Comments. It is clear that the department has historically done an inadequate job managing health records and that this deficiency has likely contributed to poor quality care, as well as fiscal inefficiencies. So, while efforts to standardize, automate, and centralize the management of inmate health records makes sense, it remains unclear whether the additional resources requested are necessary. This is because it is unclear whether the CPHCS has existing resources in its budget to do this administrative management work. Also, it remains unclear how this proposal works in concert with the HIM proposal included among the 19 projects proposed by the Receiver's Office (see Issue 7 below). The Receiver's Office states that these two proposals are in addition to each other and are not duplicative.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- What existing resources does the Receiver's Office have in its existing budget that it has been applying towards the improvement of health records management?

- Why does the remediation and support effort rely on contract staff? Who will be the vendor for these services and what are their qualifications for this type of work?

- What will be the ongoing costs for this effort, particularly the ongoing costs to expand the pilot content management project to the remaining 31 institutions?

- To which projects are all 14.1 PY's assigned? Only three state staff are identified here (for the pilot program)?

- Can the Receiver's Office clarify the distinction between what is being requested in the proposal versus what is requested as part of the HIM project listed as one of the 19 projects included in Issue 7 of this agenda?

Issue 6 – Section Letter: Redirect Position Funding to Headquarters

Background. On December 9, 2009, the Department of Finance sent to the Joint Legislative Budget Committee (JLBC) a request from the Receiver's Office to redirect $9.6 million from health care custody positions to establish additional health care positions in the Receiver's Office headquarters. The JLBC did not concur with the request and instead directed the Receiver's Office to present its proposal to this committee for the budget year.

Governor's Budget Request. The Receiver's Office proposes to redirect funding from 106.8 health care custody positions to permanently establish 81 positions in its headquarters. There would be no net cost from the proposed changes. The Receiver's Office reports that the 81 positions were already administratively established earlier this fiscal year.

	2009-10	2010-11	2011-12
General Fund	$0	$0	$0
PY's	-25.8	-25.8	-25.8

As summarized in the table below, the 81 positions would be used primarily for four categories: access to care, administration, construction, and out-of-state facilities.

Categories	PY's	Purposes
Access to care	6.0	Oversight of utilization management
Administration	36.0	Legal (8), business services (7), information technology (12), human resources (9)
Construction	28.0	Construction and renovation planning (19); retired annuitants (9)
Out-of-state facilities	11.0	Monitoring and contract oversight
Total	***81.0***	

Staff Comments. This proposal results in no net increase in costs to the state and may allow the CPHCS to better manage its $2 billion operations, as well as support its role in the development of prison construction plans totaling billions of dollars in costs under AB 900 (Solorio). However, given the ongoing nature of the request, as well as a lack of detail in the submittal to JLBC, the JLBC directed the Receiver's Office to present a more detailed proposal to this subcommittee. While the Receiver's Office has provided a much more detailed explanation of how it intends to use the proposed headquarters positions, there continues to be some additional information needed to sufficiently evaluate the plan. These issues are as follows:

- ***Overall Staffing and Funding Plan.*** The proposal does not identify what its current staffing levels are for most of these functions, making it difficult to evaluate the degree to which current staffing is insufficient. In addition, the proposal does not identify how the $9.6 million is distributed across the four categories of staffing.

- ***Access to Care.*** These positions seem to be justified under the proposal. The Receiver's Office provides data showing that utilization management efforts have reduced referrals to outside care by 36 percent during 2009, and hospital bed usage has been decreased by 19 percent over the second half of the year. While the Receiver's Office did not estimate the share of these savings directly attributable to these positions, it is highly likely that the savings would greatly exceed the cost of the six positions proposed given the costs associated with outside medical services and hospital beds.

- ***Administration.*** Some of the positions requested make more sense than others. The Receiver's Office reports that it previously had no legal positions authorized despite legal responsibilities. Also, some additional IT positions seem like they might be warranted given the number and complexity of IT projects being undertaken by the Receiver's Office. However, it is unclear how the Receiver's Office determined the need for the number of positions requested in many cases. For example, it is unclear how the IT position need was determined in light of the hundreds of additional positions being proposed under the Project Management Office: 19 Projects proposal (discussed in Issue 7 of this agenda).

- ***Construction.*** While the Receiver's Office plays an integral role in development of construction and renovation projects, and there are many such projects under development, it remains unclear the specific role of the CPHCS versus CDCR, the primary construction manager of most projects. The CPHCS also has not identified its current staffing level for these purposes or how it determined a need for 28 positions. Finally, it is unclear why it would specify that nine of these positions be reserved for retired annuitants.

- ***Out-of-State Facilities.*** It appears appropriate that an expansion of out-of-state facility usage, as proposed by the Governor, would result in additional health care workload related to oversight. However, the Receiver's request provides no information on how 11 positions were determined to be needed, nor does the proposal compare this request to its base staffing level for this purpose.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- What was the total staffing level for CPHCS headquarters and specifically for these purposes prior to the redirection of positions?

- How is the $9.6 million distributed across the different categories and purposes?

- Why did the Receiver's Office feel comfortable eliminating the 106.8 health care custody positions? Did the Receiver's Office determine that those positions were not critical to ensuring access to care in the prisons despite access being a major component of the turnaround plan? Will the elimination of those positions result in increased custody overtime costs to provide access to care?

Issue 7 – Project Management Office: 19 Projects

Background. As described above, the Receiver has submitted to the court a Turnaround Plan of Action that identifies six overarching goals and 25 more specific objectives for how it will bring inmate health care into constitutional compliance. Goals include ensuring timely access to care, providing a full continuum of health care services, providing a quality medical workforce, implementing quality improvement programs, establishing medical support infrastructure, and providing necessary facilities.

Governor's Budget Request. The Receiver's Office requests $235.4 million in 2010-11 and lesser amounts in subsequent years to implement 19 different projects designed to implement the Receiver's Turnaround Plan of Action. The Receiver has also identified $111.3 million in the current year for these projects and will seek a supplemental appropriations bill for this purpose.

	2009-10	2010-11	2011-12
General Fund	$111,264,255	$235,373,691	$209,680,487
PY's	10.6	177.3	268.4

The 19 projects cover a variety of health care operations and are mostly, though not entirely, IT related. In total, the projects are estimated to cost about $820 million over the next five years. About half of the proposed costs are associated with three projects: (1) healthcare network infrastructure, (2) clinical data repository, and (3) health care data center.

The cost for each project is identified in the table on the next page, followed by a brief description of the purpose of each project as described in CPHCS documents.

Project Management Office: 19 Projects

(Dollars in Millions)

	2009-10	2010-11	2011-12	Five Year Totals (FY 2009 - 2013)
Healthcare Network Infrastructure	$40.8	$53.5	$49.2	**$181.5**
Clinical Data Repository	$9.6	$34.3	$41.7	**$118.5**
Health Care Data Center	$10.1	$35.2	$20.7	**$107.5**
Health Information Management	$2.2	$10.8	$19.3	**$58.7**
Business Information Systems	$9.4	$13.1	$7.3	**$43.1**
Laboratory Services Mngt	$0.1	$10.2	$9.1	**$43.0**
Telemedicine Services	$0.6	$8.5	$8.7	**$41.4**
Clinical Imaging Services	$4.9	$14.5	$9.3	**$37.2**
Pharmacy - eMAR	$0.1	$13.3	$12.8	**$35.6**
Pharmacy - GuardianRx	$12.1	$7.7	$6.3	**$34.4**
Pharmacy - Central Fill	$1.0	$10.7	$6.3	**$25.4**
Strategic Offender Mngt. System	$5.2	$5.6	$5.6	**$23.0**
Health Care Scheduling System	$5.0	$6.9	$6.1	**$21.8**
End User Migration to Data Center	$5.1	$0.6	$0.8	**$17.0**
Access to Care: Utilization Mngt.	$3.0	$4.3	$3.7	**$15.1**
Centralized Dictation & Transcription	$0.8	$4.8	$2.2	**$13.1**
Mental Health Tracking System	$0.6	$0.4	$0.5	**$2.1**
Access to Care: Chronic Mngt	$0.7	$0.5	$0.0	**$1.1**
Medication Admin. Improvement	$0.1	$0.2	$0.0	**$0.3**
Totals	***$111.3***	***$235.4***	***$209.7***	***$819.8***

- ***Healthcare Network Infrastructure ($181.5 million).*** The purpose of the Healthcare Network project is to design and implement an IT network capable of providing all CDCR institutions with a common network infrastructure. Currently, the CDCR institutions do not operate under a single IT network, which means health records and other data cannot be transferred or readily shared by the institutions. The development of this network will not only provide means for institutions to securely share information but also provide the foundation necessary to implement additional IT projects in the future. The Healthcare Network will also allow institutions to be connected to outside vendors, permitting projects such as Telemedicine to be implemented at all institutions.

- ***Clinical Data Repository ($118.5 million).*** Will create and maintain a repository of health information at the point of care that is accessible twenty-four hours a day, seven days a week. These records, compiled from a variety of sources (e.g., laboratory, X-Ray, and pharmacy), will be immediately available to health care providers, even as the inmates move within the institutional system or are re-incarcerated following a release. Information in the database will enable better analysis, reporting, and clinical decision making necessary for health care providers to determine patient health status accurately, prepare recommendations, and ensure patient safety in prescriptive actions.

- ***Health Care Data Center ($107.5 million).*** The CPHCS entered into a contract to acquire data center services that are designed to host our mission critical health care information systems in a secured environment, with back up security capabilities, cooling systems, fire suppression, network links and ample storage. The data center establishes a secure, medical grade, core infrastructure to meet the current and future

needs of CPHCS health care initiatives and will provide centralized management of LAN/WAN connectivity to the 34 distributed CPHCS endsites statewide. Prior to this contract, the systems were hosted in a setting where cooling and power distribution was inadequate to run all of the computing environments and lead to disruption of services. In addition, the preventative maintenance window of opportunities shortened, which at times required the systems to be brought down for maintenance. The Health Care Data Center project establishes the core foundation for all health care information technology solutions deployed in support of the CPHCS.

- ***Health Information Management ($58.7 million).*** This project is aimed at stabilizing and remediating the volume of intensive, laborious paper process of HIM operations as well as facilitating the migration from paper-based Unit Health Records (UHRs) to hybrid UHRs (paper and electronic) and eventually to all electronic UHR (or Electronic Medical Record – EMR). This effort also includes equipment to support efficient, safe, and secures HIM operations at the institutions. This request is in addition to the funding requested under Issue 5 of this agenda.

- ***Business Information Systems (BIS) ($43.1 million).*** BIS is the central business operational management information system used by CDCR. The BIS will manage the following operational functions for the entire department, including CPHCS: accounting, budgeting, procurement, contracting, and human resources. The CPHCS participates with CDCR in the funding and implementation of the commonly used components of BIS (i.e., budget, personnel, procurement, etc.). In addition, there are components that are unique to CPHCS. The CPHCS has project leadership for the following functions: (1) medical invoice adjudication and automated payment system, and (2) nursing services shift scheduling.

- ***Laboratory Services Management (43.0 million).*** Focused on improving reference lab contracts, filling laboratory leadership positions, and addressing known shortfalls identified in lab system assessment.

- ***Telemedicine Services ($41.4 million).*** Expand telemedicine technology infrastructure and utilization, which will expand access to care and available provider pool, and reduce costly transportation of inmates.

- ***Clinical Imaging Services ($37.2 million).*** Focusing on replacing inoperable and inadequate equipment, procuring new equipment as needed, and standardizing systems and procedures, allowing ability to view imaging films statewide.

- ***Pharmacy – electronic Medication Administration Record ($35.6 million).*** The Medication Administration Record (MAR) serves as the legal paper record of the drugs distributed to a patient. Typically the MAR includes patient identification information, the medication name, dosage, frequency of distribution, scheduled time to take medication, and other vital information. Implementation of an Electronic Medication Administration Record (eMAR) provides electronic documentation of all medication distributed at point of service using barcode technologies, freeing nursing staff from the time-consuming task of documenting distributions by hand. An eMAR also provides quality control checks imperative to patient safety by positive identification of a patient and matching of that patient with the barcode verified medication. The electronic system will also allow nursing staff to record medication dispensing and will automatically track date and time

distributed, and the schedule of medication distribution. An eMAR would also alert nursing staff if a medication to be dispensed is in conflict with previously distributed medication and would indicate if any allergies are present or can cause allergic reactions.

- ***Pharmacy – GuardianRx ($34.4 million).*** The GuardianRx pharmaceutical software tracking system will create a single database that enables users to interface, track, and help facilitate the medication dispensing for all the inmate-patient specific medications, orders, usage, and the inmate history of prescribed medications. This project will establish a standardized formulary that supports the uniformity of medication and prescription business processes for medical, dental, and mental health clinical practitioner's use.

- ***Pharmacy – Central Fill ($25.4 million).*** Development of a centralized medication warehouse with an automated prescription packaging and distribution system. The automated centralized pharmacy will provide advantages of scale related to efficient purchasing, inventory control, volume production, drug distribution, workforce utilization, and increased patient safety. Currently pharmacy operations are decentralized among 33 CDCR facilities with duplicative inventory, inefficient or non-existent systems for tracking medications, and a general lack of internal controls necessary to prevent diversion and maintain accountability.

- ***Strategic Offender Management System (SOMS) ($23.0 million).*** The SOMS project is a comprehensive inmate tracking system undertaken by the CDCR. When complete, SOMS will consolidate existing databases and records to provide a fully automated system, replacing manual paper processes and upgrading and standardize data and population management practices. The SOMS is essential to all of the CPHCS information technology projects. It provides access to basic data, such as: general inmate information; inmate location; and, special needs (such as, those related to the Americans with Disability Act (ADA), interpreters, or special housing). The SOMS also provides the infrastructure necessary for different projects to share information, including projects dealing with medical care management, health care scheduling, pharmaceutical dispensing, and contract billing.

- ***Health Care Scheduling System ($21.8 million).*** The Health Care Scheduling System (HCSS) will provide the capability to track requests for care, referrals, and appointments regardless of an inmate's location or the location of the appointment. The system will be fully integrated with SOMS.

- ***End User Migration to Data Center ($17.0 million).*** This project represents the final step in adding users to the new CPHCS network. As the network project finalizes construction at a site, the End User Migration team will follow the completion and assist local staff in moving the computers onto the new network. The new network will give users faster access to the programs being launched by CPHCS like Clinical Data Repository, Dictation & Transcription, Unit Health Record and Health Care Scheduling, to name a few. This project also involves migrating the Maxor workstations off of the independent Maxor network and onto the new CPHCS network. This will represent a significant cost savings as well as allow us to recapture equipment and repurpose it.

- ***Access to Care: Utilization Management ($15.1 million).*** This project will reduce unnecessary expenditures by implementing evidence-based decision systems related to medical specialty referrals. Also, will focus on improving oversight of institutional bed use. Freeing institutional beds provides vacancies to allow patient-inmates to be discharged from expensive community hospitals and cared for in less expensive institution infirmary beds. UM processes also provide data that supports institution compliance with standardized processes, monitoring of outcomes, and enables necessary clinical and educational interventions.

- ***Centralized Dictation and Transcription ($13.1 million).*** Aimed at eliminating backlogs of transcribed physician notes and providing clinicians with accessibility to timely, legible and accurate health information. Will also provide increased efficiency and reduced costs through centralization of dictation and transcription services.

- ***Mental Health Tracking System ($2.1 million).*** The Mental Health Tracking System (MHTS) project replaces legacy applications used at CDCR's adult institutions. Users of the current systems frequently report internal system malfunctions, the inability to connect to other systems, and difficulty running required reports. Each institution has a unique tracking system with undocumented modifications making it difficult for IT staff to repair and maintain. Reports cannot always be generated out of the data that is shared between institutions. These systems pose a problem in providing mental health services when the patient-inmates are moved from institution to institution because of the inability to share and view data from the various legacy applications. The MHTS will be a web-based application for tracking and reporting of mental health services with a centralized database that can be accessed by all 33 adult institutions. The web-based application and centralized data repository will enable sharing of standardized information between adult institutions. It will also enhance the headquarters oversight capabilities of patient-inmate care at the institutions.

- ***Access to Care: Chronic Management ($1.1 million).*** The Access to Care Project has the following objectives: (1) implement a Primary Care Model (developing a consistent relationship between a patient panel and a Primary Care Team), (2) implement an Episodic Care Model (improving systems intended to provide medical services in response to unexpected medical conditions, e.g., sick call), (3) improve Screening and Assessment Processes through implementation of a Medical Classification System, and (4) implement a Chronic Disease Management and Prevention program.

- ***Medication Administration Improvement ($0.3 million).*** Process redesign focused on increasing timely, efficient and error-free administration of medications to inmates.

Staff Comments. The current state of the inmate health record keeping is clearly inefficient. The medical records for hundreds of thousands of inmates (including current and prior inmates and parolees) are kept in paper files spread across dozens of locations. These records are frequently incomplete or missing when inmates arrive at the reception center, are transferred to a new institution, arrive at prison health care clinics, or are referred to outside health care providers. While expensive to implement, it is likely that the implementation of these projects could result in significantly better treatment for inmates. It is also possible that a more centralized automated health records system could result in efficiencies that reduce duplication and lost time, resulting in lower inmate health care costs.

While these potential benefits exist, there are some downside risks to undertaking the projects. Most significantly, the size of the project portfolio is reason for some concern. Simultaneously implementing a total of 19 projects with a cost of an estimated $820 million over the next five years (and about $96 million annually in ongoing costs) is a major undertaking for such a young organization, as well as one that exists in conjunction with a department (CDCR) and prison system that has not historically been technologically well equipped. It is also worth noting that the IT projects undertaken by the CPHCS have not been subject to the review or approval of the Office of the Chief Information Officer as is required for all state IT projects. This means that there is not likely to be the level of administrative oversight over these projects that could better ensure success or early identification of problems.

It is also worth noting that it is unclear whether there is existing funding in the department's base budget that could be utilized towards these projects. As described above, the budget for prison health care has increased by $1.4 billion since the inception of the *Plata* case. While much of that additional spending authority is for things unrelated to the implementation of these projects (e.g. increased medical staff and salaries), it is unclear the extent to which the Receiver's Office is applying any funds provided by the Legislature in past budget cycles for purposes of improving medical care and health records towards these projects. For example, the Legislature has already approved millions of dollars for the expansion of telemedicine and improvement of pharmacy systems.

Finally, staff would note that given the number, scope, and costs of these projects, it will be important for the Legislature to remain informed about the status of their implementation, particularly if there are any major cost overruns. Therefore, it may be worth seeking a commitment from the Receiver's Office to provide a regular status update on the projects, perhaps in conjunction with his tri-annual reports to the federal court.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- How is the Receiver's Office able to manage such a large portfolio of projects all at the same time? What staffing and contract resources in the Receiver's base budget are dedicated to these efforts as distinguished from resources devoted to the day to day management of the existing system?

- Are additional resources really necessary for the non-IT portion of these projects? To the extent that some of these projects involve developing new standards, procedures, routines, and policies, why is the existing administrative and management personnel insufficient or unable to do that work?

- To what extent are the IT projects commercial off the shelf systems already developed versus ones being created new?

- What are the ongoing costs of these projects considering that, while many of these are implementation projects, they will also require some level of resources for ongoing maintenance and training?

- Are there likely to be savings associated with any of these projects, either in the near term or longer term, because of greater efficiencies, for example? What would be some examples of such efficiencies? Has the administration or Receiver's Office attempted to estimate the magnitude of such efficiencies and savings?

- What is the current status of these projects? Are they all on schedule and on budget to date? Will the CPHCS keep the Legislature apprised of the progress of implementation going forward?

- What will happen if projects go significantly over budget?

- When will the automation of inmate health records be completed statewide?

Issue 8 – Unallocated Reduction of $811 Million

Background. The cost of inmate medical care (excluding mental health, dental care, and health care administration) is projected to be $10,482 per inmate in the current year. The administration reports that this is significantly greater than other states. For example, the average inmate health care cost in New York is $5,757 and in Florida is $4,720. The administration attributes much of high costs in California to factors including high staffing ratios, high staff salaries, and greater use of contract medical services.

Governor's Budget Request. The administration proposes to reduce the budget for inmate health care by $811 million. This would result in bringing the average cost for inmate health care to about $5,740, comparable to the level of New York.

	2009-10	2010-11	2011-12
General Fund	$0	-$811,000,000	-$811,000,000
PY's	0.0	0.0	0.0

Staff Comments. Though this reduction was proposed by the administration, the Receiver's Office has stated its support for the proposal and its intention to achieve the budgeted savings level. However, the Receiver's Office reports that it has not yet determined how it will achieve these savings and is currently reviewing various alternatives.

Currently, the Department of Finance's Office of State Audits and Evaluations (OSAE) is developing a staffing analysis of the California prison medical system as compared to other states. The administration and Receiver's Office believe the results of this study – to be completed in April – may provide some insights.

In addition, the administration's budget proposal notes that other states utilize different health care models in prisons that may be somewhat less expensive. For example, Pennsylvania contracts for some services – medical, psychiatric, and pharmacy – while using state employees for other functions, and Texas contracts with the University of Texas Medical Branch to provide prison health care services.

In weighing this funding request, the committee may wish to direct the following questions to the Receiver's Office.

- What are the types of approaches the Receiver's Office and administration are considering for reaching the proposed $811 million in savings?

- Is it realistic to believe that a savings level of that magnitude can be achieved in the budget year? If efforts fall short, what are the consequences?

- What is the status of Finance's OSAE audit?

- How did the administration determine that New York was the right state to which to compare California's average cost for inmate health care? Did Finance look at other states, as well?